

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The best copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11825

11814

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH COUNTY <u>Charles</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Port Tobacco</u> OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rural</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Charles</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Port Tobacco</u> OR TOWN STREET ADDRESS (If rural give location) <u>Rural</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>Bahy</u> (Middle) <u>Bay</u> (Last) <u>Adams</u>				4. DATE OF DEATH (Month) <u>11</u> (Day) <u>1</u> (Year) <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>11-1-57</u>	9. AGE last birthday <u>0</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>5</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>5</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Adams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Mrs. Ruth Adams, Port Tobacco, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
776x IMMEDIATE CAUSE (A) <u>Prematurity - 25 weeks</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>			
ANTECEDENT CAUSE(S) DUE TO <u>—</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>—</u>							
(C) <u>—</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>—</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>midnight</u> to <u>10:05 P</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/2/57</u> , and that death occurred at <u>10:05 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>J B Dettor</u>				ADDRESS (Street, city, town, state) <u>La Plata Md.</u>			
DATE <u>11/2/57</u>				DATE SIGNED <u>11-2-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>11/2/57</u>		NAME OF CEMETERY OR CREMATORY <u>SACRED HEART</u>		LOCATION (City, town, or county) (State) <u>LA PLATA MD</u>	
24. REC'D BY REGISTRAR <u>Julia H Paay</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth Adams</u>		ADDRESS <u>Port Tobacco, Md.</u>	

CERTIFICATE OF DEATH

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN, OR OTHER PERSON QUALIFIED TO CERTIFY TO THE CAUSE OF DEATH, AND TO BE SIGNED BY HIM OR HER, AND TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, WHO SHALL THEREUPON ISSUE A CERTIFICATE OF DEATH, WHICH SHALL BE A VALID DOCUMENT FOR ALL PURPOSES.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

NAME OF DECEASED: [Faint text]

AGE: [Faint text]

SEX: [Faint text]

RACE: [Faint text]

DATE OF BIRTH: [Faint text]

PLACE OF BIRTH: [Faint text]

EDUCATION: [Faint text]

OCCUPATION: [Faint text]

CAUSE OF DEATH: [Faint text]

DATE OF DEATH: [Faint text]

PLACE OF DEATH: [Faint text]

TIME OF DEATH: [Faint text]

TIME OF BURIAL: [Faint text]

PLACE OF BURIAL: [Faint text]

TIME OF INTERMENT: [Faint text]

PLACE OF INTERMENT: [Faint text]

TIME OF CREMATION: [Faint text]

PLACE OF CREMATION: [Faint text]

TIME OF DISPOSITION: [Faint text]

PLACE OF DISPOSITION: [Faint text]

TIME OF REINTERMENT: [Faint text]

PLACE OF REINTERMENT: [Faint text]

TIME OF RECREMATION: [Faint text]

PLACE OF RECREMATION: [Faint text]

TIME OF REINTERMENT: [Faint text]

PLACE OF REINTERMENT: [Faint text]

TIME OF RECREMATION: [Faint text]

PLACE OF RECREMATION: [Faint text]

TIME OF REINTERMENT: [Faint text]

PLACE OF REINTERMENT: [Faint text]

TIME OF RECREMATION: [Faint text]

PLACE OF RECREMATION: [Faint text]

TIME OF REINTERMENT: [Faint text]

PLACE OF REINTERMENT: [Faint text]

TIME OF RECREMATION: [Faint text]

PLACE OF RECREMATION: [Faint text]

TIME OF REINTERMENT: [Faint text]

PLACE OF REINTERMENT: [Faint text]

TIME OF RECREMATION: [Faint text]

PLACE OF RECREMATION: [Faint text]

BUREAU V. S.

NOV 5 1937

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11815 CERTIFICATE OF DEATH

11826

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Plains, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital				e. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas J. BEACH				4. DATE OF DEATH Month 11 Day 1 Year 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept/29/1901		9. AGE (In years lost birthday) 56 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farmer		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME William R. Beach				14. MOTHER'S MAIDEN NAME Mary C. Harrison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 237 24 973		17. INFORMANT patient or deceased			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage 521X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic lung abscess DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 days 1 year						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month 11 Day 1 Year 1957 Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 21, 1956 to Nov 1, 1957 , that I last saw the deceased alive on Nov 1, 1957 , and that death occurred at 9:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE F. M. JOHNSON M.D.				ADDRESS (Street, city or town, state) La Plata Md DATE SIGNED 11-1-57			
PHYSICIAN'S NAME (Type) F. M. JOHNSON M.D.				ADDRESS (Street, city or town, state) La Plata Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-5-57		22c. NAME OF CEMETERY OR CREMATORY Full Gospel		22d. LOCATION (City, town, or county) (State) Codanville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home				ADDRESS WALDORE Md.		24a. REC'D BY REGISTRAR DATE 11/5/57	
				24b. REGISTRAR'S SIGNATURE Julia H. Mason			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		OTHER			
OCCUPATION		PROFESSION		VOCATION		INDUSTRY		BUSINESS		ART		SCIENCE		LITERATURE	
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		INSTITUTION		ACADEMY		SEMINARY		OTHER	
RELIGION		METHODIST		BAPTIST		CATHOLIC		LUTHERAN		PRESBYTERIAN		ANGELICAN		OTHER	
CAUSE OF DEATH		DISEASE		INJURY		POISON		SUFFOCATION		DROWNING		FIRE		OTHER	
MANNER OF DEATH		NATURAL		ACCIDENTAL		SUICIDE		HOMICIDE		OTHER					
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH					
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF		SIGNATURE OF	

BUREAU V. 3

NOV 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11827

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pomfret</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>CHARLES</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Pomfret</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARRILYN</u> First Middle Last 4. DATE OF DEATH <u>Nov 18 1957</u> Month Day Year		5. SEX <u>F</u> 6. COLOR OF RACE <u>N</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>APRIL 24-56</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>1</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____ 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (State or foreign country) <u>D.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>SWEENEY BEALE</u> 14. MOTHER'S MAIDEN NAME <u>MARY P. TRAVERS</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ 16. SOCIAL SECURITY NO. _____ 17. INFORMANT <u>SWEENEY BEALE</u> Address <u>Pomfret Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X Broncho-pneumonia</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>11-18-57</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>[Signature]</u> EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>11-14-57</u> 22c. NAME OF CEMETERY OR CREMATORY <u>St Joseph's Cem.</u> 22d. LOCATION (City, town, or county) <u>Pomfret Md.</u> (State) <u>md.</u>		24a. REC'D BY REGISTRAR <u>[Signature]</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u> DATE <u>11/22/57</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home</u> ADDRESS <u>Waldorf Md.</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE	
19. SIGNATURE OF VENDOR		20. SIGNATURE OF CEMETERY		21. SIGNATURE OF INTERMENT	
22. SIGNATURE OF BURIAL		23. SIGNATURE OF CREMATION		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER	
40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER	
43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER	
52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER	
55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER	
58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER	
64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER	
70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER	
82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER	
88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER	
94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

RECEIVED
NOV 26 1957
BUREAU V. 3

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11817

CERTIFICATE OF DEATH

11828
100

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LA PLATA.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Memorial Hosp.</u>				d. STREET ADDRESS <u>7102 14th Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Allen</u> Last <u>Billingsley</u>				4. DATE OF DEATH Month <u>November</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 4, 1903</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Federal Baking Company</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William B. Billingsley</u>				14. MOTHER'S MAIDEN NAME <u>Carrie B. Lusby</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Roger H. Billingsley-5030 33rd Road, N.</u>			
17. INFORMANT <u>Arlington, Va.</u>				Address <u>33rd Road, N.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory collapse</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>C.I.U.A.</u> DUE TO (c) <u>Carcinoma, lung, with metastases</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs.</u> <u>6 hrs.</u> <u>9 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 <u>57</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 15, 1957</u> , to <u>11 Nov</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11 Nov</u> , 19 <u>57</u> , and that death occurred at <u>2:50 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Arthur C. Woody</u> M.D. <u>La Plata, Md.</u>				PHYSICIAN'S NAME (Type) <u>ARTHUR C. WOODY, M.D. LA PLATA, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>11/13/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>McKendree Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Brandywine, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.-2901 14th St., N.W.</u>				24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <u>NOV 12 1957</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 1, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11829

Reg. Dist. No. 100

11818

1. PLACE OF DEATH o. COUNTY Charles b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Charles Middle E Last Burch			4. DATE OF DEATH Month Nov. Day 24 Year 19 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 20, 1907	9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Ambrose Burch			14. MOTHER'S MAIDEN NAME Mary E. Wood		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Edith Burch Address WALDORF, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull & Fractured Neck 812X DUE TO Crushed Chest, Bilateral Fractures(Comp) Conditions, if any, which gave rise to immediate cause (b) Tibia & Fibula (c) Automobile Accident (Pedestrian) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pedestrian walking on highway hit by auto					INTERVAL BETWEEN ONSET AND DEATH Instantly
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian walking on highway hit by auto			
20c. TIME OF INJURY Month, Day, Year 6 11-24-57	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Waldorf Charles Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Vernon B. Dettor		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11-25-'57	
EXAMINER'S NAME (Type) Vernon B. Dettor, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11-27-57	22c. NAME OF CEMETERY OR CREMATORY St Peters Cem		22d. LOCATION (City, town, or county) (State) WALDORF Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home		ADDRESS WALDORF, Md.		24a. REC'D BY REGISTRAR DATE 11/30/57	24b. REGISTRAR'S SIGNATURE Julius H. Haney

STATE DEPARTMENT OF HEALTH - BALTIMORE 19
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "45"]		RACE [Faint text, possibly "White"]	
DATE OF DEATH [Faint text, possibly "Dec 2, 1957"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]	
PLACE OF DEATH [Faint text, possibly "Home"]		STREET [Faint text, possibly "123 Main St"]	
CITY [Faint text, possibly "Baltimore"]		STATE [Faint text, possibly "MD"]	
ZIP CODE [Faint text, possibly "21201"]		COUNTY [Faint text, possibly "Baltimore"]	
OCCUPATION [Faint text, possibly "Teacher"]			
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]			
MANNER OF DEATH [Faint text, possibly "Natural"]			
SIGNATURE OF EXAMINER [Faint signature]			
DATE OF EXAMINATION [Faint text, possibly "Dec 2, 1957"]			
TIME OF EXAMINATION [Faint text, possibly "10:00 AM"]			
PLACE OF EXAMINATION [Faint text, possibly "Home"]			
STREET [Faint text, possibly "123 Main St"]			
CITY [Faint text, possibly "Baltimore"]			
STATE [Faint text, possibly "MD"]			
ZIP CODE [Faint text, possibly "21201"]			
COUNTY [Faint text, possibly "Baltimore"]			

BUREAU V. 1

DEC 3 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The doctor's copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11830

11819

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH COUNTY <u>CHARLES</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural - Mt Victoria</u> LENGTH OF STAY (in this place) <u>Life</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Chas.</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural - Mt Victoria</u> STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>John HENRY Carroll</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 1 19 57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>9-16-81</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Henry Carroll</u>				14. MOTHER'S MAIDEN NAME <u>BARBARA CAROLINE CHAPMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT & ADDRESS <u>Hannah M. Butler Newburg Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.0 IMMEDIATE CAUSE (A) <u>Respiratory Collapse.</u>						<u>10 min</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>C.U.A.</u>						<u>48 hrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arterio-sclerotic hypertension</u>						<u>10 yrs.</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>heart disease</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 19 47</u> , to <u>Nov 1, 19 57</u> , that I last saw the deceased alive on <u>Nov 1, 19 57</u> , and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. Wooddy MD</u>				ADDRESS (Street, city, town, state) <u>LaPlata. Md.</u>		DATE SIGNED <u>1 Nov 57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>11-5-57</u>		NAME OF CEMETERY OR CREMATORY <u>Shiloh M.E. Cem</u>		LOCATION (City, town, or county) (State) <u>Wayside, Md.</u>	
24. REC'D BY REGISTRAR <u>11/6/57</u>		REGISTRAR'S SIGNATURE <u>Julia H. Pasen</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u>		ADDRESS <u>Waldorf Md.</u>	

VS. A15ME(5)
5M 9/55

1. PLACE OF DEATH a. COUNTY <u>Charles</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marbury</u>		c. LENGTH OF STAY IN lb <u>4 mos</u> x2 <u>Granton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Jessie S</u> <u>DAVIS</u>		4. DATE OF DEATH Month <u>11</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-30</u>
9. AGE (In years and birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Bryson</u>		14. MOTHER'S MAIDEN NAME <u>Christiana Turner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		15. SOCIAL SECURITY NO.	
16. INFORMANT <u>Carol B. Bryan Jr.</u>		Address <u>Granton Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial failure</u> <u>9040</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>fracture left humerus</u> DUE TO (c) <u>11-12-57</u> <u>10-18-57</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall from left humerus</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>10-18</u> <u>12</u> <u>7</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Granton Charles</u> (County) <u>Md</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. J. Fedelin</u>		DATE SIGNED <u>11-14-57</u>	
EXAMINER'S NAME (Type) <u>E. J. Fedelin MD</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-15-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Granton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Orbert Mc Laplata MD</u>		ADDRESS <u>Granton Md</u>	
24a. REC'D BY REGISTRAR <u>11/19/57</u>		24b. REGISTRAR'S SIGNATURE <u>Julius Posen</u>	

NOV 20 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11821

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11832
100

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pomonkey		c. LENGTH OF STAY IN 1b 86-Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Pomonkey			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Thomas Day First Middle Last				4. DATE OF DEATH 11-14-57 Month Day Year			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-15-70		9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY US*Govt.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Alice Campbell- (Daughter)-Bryans Road Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Small Intestines 152x DUE TO Conditions, if any, which gave rise to immediate cause (b) Senility (c) Senility DUE TO (c) Senility PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility						INTERVAL BETWEEN ONSET AND DEATH Indefinite	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James E. Andrews				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James E. Andrews MD.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-18-57		22c. NAME OF CEMETERY OR CREMATORY Metropolitan Cem.		22d. LOCATION (City, town, or county) (State) Pomonkey Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home				ADDRESS WATLOO ST. Md.		24a. REC'D BY REGISTRAR DATE 11/20/57	
				24b. REGISTRAR'S SIGNATURE Julia H. Pacey			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES J. JONES		45		M		W		1880		BALTIMORE		MD		USA		USA	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		MILITARY SERVICE		PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER	
Carpenter		High School		Married		Catholic		None		None		Heart Disease		Natural		J. J. Jones	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		SIGNATURE OF NEXT OF KIN		RELATIONSHIP		DATE		TIME	
Nov 22 1937		Home		Baltimore		MD		USA		J. J. Jones		Son		Nov 22 1937		10:00 AM	
TESTIMONY OF DECEASED		TESTIMONY OF WITNESSES		TESTIMONY OF PHYSICIAN		TESTIMONY OF MENTAL EXAMINER		TESTIMONY OF PATHOLOGIST		TESTIMONY OF FORENSIC EXAMINER		TESTIMONY OF JURY		TESTIMONY OF COURT		TESTIMONY OF JUDGE	
None		None		None		None		None		None		None		None		None	

BUREAU V. 81

NOV 22 1937

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11822

CERTIFICATE OF DEATH

11833

Reg. Dist. No. 100

1. PLACE OF DEATH o. COUNTY CHARLES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAPLATA				c. LENGTH OF STAY IN 1b 13 days.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Rural - Cobb Island.				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physician Memorial Hosp.			
d. STREET ADDRESS 1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Atticus Middle M. Last Earney				4. DATE OF DEATH Month Nov Day 25 Year 1957			
5. SEX Male		6. COLOR OR RACE US-W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 17 Mar 1887	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 70 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRICK LAYER	
10b. KIND OF BUSINESS OR INDUSTRY Industrial		11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME M. D. EARNEY	
14. MOTHER'S MAIDEN NAME MARY chester		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) PRE WWI		16. SOCIAL SECURITY NO. 220343572		17. INFORMANT REGINA M. EARNEY Address Cobb Island, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Respiratory Collapse. DUE TO C.U.A. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive renal disease DUE TO 1 year (c) 1 year				INTERVAL BETWEEN ONSET AND DEATH 2 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Calcified prostate, chronically infected.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 54 , to 25 Nov , 19 57 . That I last saw the deceased alive on 25 Nov , 19 57 , and that death occurred at 4:46 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE St. Wooddy M.D.				ADDRESS (Street, city or town, state) La Plata Md DATE SIGNED 27 Nov 57			
PHYSICIAN'S NAME (Type) ARTHUR O. WOODDY MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-29-57		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEM.		22d. LOCATION (City, town, or county) (State) ARLINGTON, VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Huntl Funeral Home ADDRESS WALDORE, Md.				24a. REC'D BY REGISTRAR 12/3/57		24b. REGISTRAR'S SIGNATURE Julia H. Pacey	

MEDICAL CERTIFICATION

BUREAU V. S.

DEC 6 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11834

11823

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>Pisgah</u>		LENGTH OF STAY (in this place) <u>58</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pisgah</u>		TOWN <u>Pisgah</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>George</u> (Middle) <u>N.</u> (Last) <u>Greer Jr.</u>				Nov. 17 1957			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>9-13-99</u>	9. AGE last birthday <u>58</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Old Jobs</u>		11. BIRTHPLACE (State or foreign country) <u>Pisgah MD</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>George N. Greer</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Ross</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-14-8680</u>		17. INFORMANT & ADDRESS <u>John R Greer, Indian Head, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>Arthritis, Generalized</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/7/57</u> , 19 <u>57</u> , to <u>11/17/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/15/57</u> , 19 <u>57</u> , and that death occurred at <u>4:20 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Frank A. Susan</u>		M.D.		ADDRESS (Street, city, town, state) <u>Indian Head, MD</u>		DATE SIGNED <u>11-17-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-21-57</u>		NAME OF CEMETERY OR CREMATORY <u>Smith Chapel Cem.</u>		LOCATION (City, town, or county) (State) <u>Pisgah, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Julia H. Carey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u>		ADDRESS <u>WALDORE, MD.</u>	
DATE <u>11/22/57</u>							

[illegible]

NOV 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11824 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13049

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RT. #5 HUGHESVILLE TRANSIENT</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) ✓ a. STATE <u>MD</u> b. COUNTY <u>St Marys</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lexington Park 18X2.2</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN DAVID HODGES JR.</u>			4. DATE OF DEATH Month Day Year <u>NOVEMBER 28 1957</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 28 1957</u>	9. AGE (In years last birthday) yrs. <u>5</u>	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHILD</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>OKLA.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
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13. FATHER'S NAME <u>John D. Hodges, Sr.</u>	14. MOTHER'S MAIDEN NAME <u>Dorothy Ellen Pate</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>John D. Hodges, Sr.</u> Address <u>Lexington Park, MD.</u>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASPHYXIAATION; ASPIRATION OF STOMACH CONTENTS</u> <u>816X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>BRAIN CONCUSSION</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 MINUTES</u> <u>10 MINUTES</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>ON MD. RT #5, 1 MILE SOUTH OF HUGHESVILLE, MD. VEHICULAR COLLISION</u>
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20c. TIME OF INJURY Hour <u>11:20</u> p. m. Month, Day, Year <u>11/28 1957</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HIGHWAY</u>	20f. (City or town) (County) (State) <u>HUGHESVILLE, CHARLES, MD.</u>
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21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE <u>John H. Griffin</u> M.D.	DATE SIGNED <u>11/29/57</u>
EXAMINER'S NAME (Type) <u>JOHN H. GRIFFIN, MD.</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	22b. DATE THEREOF <u>12-6-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HUNT FUNERAL HOME</u> ADDRESS <u>WALDORE, MD.</u>	22d. LOCATION (City, town, or county) (State) <u>OKLA. CITY OKLA.</u>
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23. FUNERAL DIRECTOR'S SIGNATURE <u>HUNT FUNERAL HOME</u>	24a. REC'D BY REGISTRAR DATE <u>12/9/57</u>	24b. REGISTRAR'S SIGNATURE <u>Julia H. Haney</u>
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9VVVVVVVV XVV

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
DEC 11 1957
BUREAU V. S.

11825

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11835

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>WASHINGTON</u> b. COUNTY <u>D.C.</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RT #5, HUGHESVILLE</u>		c. LENGTH OF STAY IN 1b <u>NONE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON, D.C. 47X-3</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES THOMAS JORDAN</u>		d. STREET ADDRESS <u>1369 PERRY PLACE, N.W.</u>	
4. DATE OF DEATH Month Day Year <u>NOVEMBER 28 1957</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 27, 1913</u>
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>JANITOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BLDG. MAINTENANCE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>IRELAND JORDAN</u>		14. MOTHER'S MAIDEN NAME <u>JANE M. FENWICK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>UNKNOWN</u>	
17. INFORMANT (WIFE) <u>ESTELLE JORDAN</u>		Address <u>1369 PERRY PLACE, N.W. WASHINGTON, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>FRACTURE, SKULL, BASAL</u> 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>MULTIPLE FRACTURES (3-4-5-6-7-8 RIBS RT.; RIGHT ULNA; RIGHT TIBIA; RIGHT FEMUR; RIGHT FIBULA)</u> (c) <u>COMPOUND, COMMINUTED FRACTURES OF LEFT</u> TIBIA AND FIBULA PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>TIBIA AND FIBULA</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>INSTANTANEOUS</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>VEHICULAR COLLISION ON MD. RT #5, 1 MILE SOUTH OF HUGHESVILLE, MD.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>11:20</u> p. m. <u>11/28 1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HIGHWAY</u>		20f. (City or town) (County) (State) <u>HUGHESVILLE, CHARLES, MD.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>John H. Griffin</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN H. GRIFFIN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Dec. 2, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Georges</u>		22d. LOCATION (City, town, or county) (State) <u>St. Georges Island Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home, Waldorf, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>12/3/57</u>	
24b. REGISTRAR'S SIGNATURE <u>Julia H. Paez</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the register prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12
1957 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, time, place, and cause of death. The form is oriented horizontally but contains vertical text labels for various sections.

RECEIVED
DEC 6 1957
BUREAU V. S.

11826

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>CHARLES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LA PLATA</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Physicians Memorial Hosp.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XI BRYANTOWN RURAL</u>			
4. DATE OF DEATH Month <u>11</u> Day <u>3</u> Year <u>1957</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MICHAEL C. PROCTOR</u>		5. SEX <u>MALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>FEB 3 1944</u>		9. AGE (In years last birthday) <u>13</u> yrs.		IF UNDER 1 YEAR Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min. <u>13</u>		IF UNDER 24 HRS. Hours <u>13</u> Min. <u>13</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Richard Hayes Proctor Jr.</u>				14. MOTHER'S MAIDEN NAME <u>CATHERINE PROCTOR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>HAYES PROCTOR</u>				Address <u>WALDORE, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fluid and Electrolyte Loss</u> INTERVAL BETWEEN ONSET AND DEATH <u>15 hours</u> 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Second Degree Thermal Burns - 100%.</u> <u>15 hours</u> (c) <u>—</u> DUE TO (a) <u>—</u> (b) <u>—</u> (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Kerosene stove explosion</u>			
20c. TIME OF INJURY Month, Day, Year <u>7:30 P.M. 11-2-1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HOME</u>		20f. (City or town) (County) (State) <u>Malcolm Charles Maryland</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>V. B. DETTOR</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>V. B. DETTOR</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-6-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART CEM</u>		22d. LOCATION (City, town, or county) (State) <u>LA PLATA MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HUNT FUNERAL HOME</u>				ADDRESS <u>WALDORE, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>11/11/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Julia Massey</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH OR IS
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		PLACE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____	
MANNER OF DEATH _____		MEDICAL HISTORY _____	
PRESENT ILLNESS _____		TREATMENT _____	
SIGNATURE OF EXAMINER _____		DATE _____	

RECEIVED
 NOV 13 1957
 BUREAU V. 3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11827 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11837
Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>CHARLES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LA PLATA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WELCOME</u>	
NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Physicians Memorial Hosp.</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>DOROTHY C. SHORT</u>		4. DATE OF DEATH Month <u>11</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 17, 1928</u>
9. AGE (In years last birthday) <u>29</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NO JOB</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>MD</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>JESSIE SHORT</u>		14. MOTHER'S MAIDEN NAME <u>EMMA JORDON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>EMMA WHITING</u>		Address <u>2205 FRANKLIN NE. WASH., D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cranial Trauma</u> DUE TO (c) <u>Auto Accident</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u> <u>8 hrs.</u> <u>8 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertrophic Heart Disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>auto accident</u>	
20c. TIME OF INJURY Month, Day, Year <u>11-18 1957</u> Hour <u>12:50</u> a.m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. (City or town) (County) (State) <u>PORT TOWN, CHARLES, MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>V. B. DETTOR</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>V. B. DETTOR, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>11-18-57</u>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-20-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ZION HILL CEM</u>	22d. LOCATION (City, town, or county) (State) <u>HILL TOP, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HUNT FUNERAL HOME</u>		ADDRESS <u>WALDORE, MD.</u>	
24a. REC'D BY REGISTRAR DATE <u>11/22/57</u>		24b. REGISTRAR'S SIGNATURE <u>JUDITH H. PASEY</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. JONES		45		M		W		11-20-57		HOME	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		CAUSE OF DEATH		MANNER OF DEATH	
1234 Main St., Boston, Mass.		Carpenter		High School		Married		Heart Disease		Natural	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF ENTRY INTO STATE		DATE OF ENTRY INTO COUNTRY		DATE OF ENTRY INTO CITY		DATE OF ENTRY INTO STATE	
11-20-12		New York		1945		1945		1945		1945	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
11-20-57		HOME		11-20-57		HOME		11-20-57		HOME	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
11-20-57		HOME		11-20-57		HOME		11-20-57		HOME	

BUREAU V. S.

NOV 26 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11838
100

11828

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY CHARLES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) VERONICA SYLVIA THOMPSON				4. DATE OF DEATH # 11-28 1957			
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-30-57		9. AGE (In years last birthday) yrs. 3	IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min. 3	IF UNDER 24 HRS. Months 3 Days 3 Hours 3 Min. 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) LA PLATA, MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WM. GONZA THOMPSON				14. MOTHER'S MAIDEN NAME MARY ALINE PROCTOR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT Address GONZA THOMPSON, LA PLATA, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Increased Intracranial Pressure 752x DUE TO (b) Hydrocephalus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) 70 days 70 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-10 , 19 57 , to 9-10 , 19 57 , that I last saw the deceased alive on 9-10 , 19 57 , and that death occurred at 2:30 AM , from the causes and on the date stated above. DATE SIGNED 11-29-57 ACTUAL SIGNATURE V. B. DETTOR M.D. Box 397 PHYSICIAN'S NAME (Type) V. B. DETTOR, M.D. La Plata, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/29/57		22c. NAME OF CEMETERY OR CREMATORY St IGNATIUS		22d. LOCATION (City, town, or county) (State) BEL ALTON, MD	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HEHART Funeral Home LA PLATA				24a. REC'D BY REGISTRAR DATE 11/29/57		24b. REGISTRAR'S SIGNATURE Julia H. Basing	

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11829

CERTIFICATE OF DEATH

11839

Reg. Dist. No. 101

1. PLACE OF DEATH a. COUNTY <i>Charles Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <i>Chas. Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ironsides-Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ironsides x2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>SARAH H. WARREN</i>		4. DATE OF DEATH Month <i>Nov</i> Day <i>15</i> Year <i>1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-15-1886</i>
9. AGE (In years last birthday) <i>71</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>11</i> Days <i>15</i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>house wife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Chas. Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>Charles</i>	
13. FATHER'S NAME <i>John Henry Henson</i>		14. MOTHER'S MAIDEN NAME <i>Emma Queen Pisgah-Md.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Edna Simmons</i>		Address <i>Ironsides, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septicemia</i> <i>0533</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>infected left foot</i> DUE TO (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>arteriosclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>11-14</i> , 19 <i>57</i> , to <i>11-15</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>11-14</i> , 19 <i>57</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>F. M. JOHNSON</i> M.D.		ADDRESS (Street, city or town, State) DATE SIGNED <i>La Plata Md. 11-18-57</i>	
PHYSICIAN'S NAME (Type) <i>F. M. JOHNSON M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11-19-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Smith Chapel Church</i>	22d. LOCATION (City, town, or county) (State) <i>Pisgah Chas. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Tehrisson and Jenkins</i>		ADDRESS <i>4804 Georgia Ave</i>	
24a. REC'D BY REGISTRAR DATE <i>11-18-57</i>		24b. REGISTRAR'S SIGNATURE <i>Mary Smith</i>	

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